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# Development

# Personal medical services: local organizational developments

**Geoffrey Meads** Centre for Primary Health Care Studies, University of Warwick, UK, **Anthony J. Riley** Royal Free and University College Medical School, London, UK, **Geoffrey Harding** Barts and The London Queen Mary School of Medicine and Dentistry, London, UK, **Yvonne H. Carter** Medical School, University of Warwick, UK

Devolved accountability for primary care has been introduced into the UK through a range of local contracts for personal medical services (PMS) authorized by the 1997 NHS (Primary Care) Act. These four exemplary case studies illustrate the PMS pilot programmes and represent a diversity of emerging organizational developments that appear to be responding effectively to different health care needs and environments. This is particularly apparent at those sites targeting the most marginalized patient groups where interprofessional collaboration and interagency partnerships are characteristic of a new and broader primary health care approach. Elsewhere the PMS pilots retain and indeed may extend some of the more restrictive practices of the conventional primary medical care model. Future policy formulation, therefore, needs to promote flexible management structures and processes which can support, through local contracts, the further development of more comprehensive and population-based primary care.

**Key words:** inequalities in health; local service contract; organization development; personal medical service; primary care

## Context

The primary medical care model of service based upon the general medical practitioner providing nationally defined general medical services (GMS) continued until April 1997 to be a legal monopoly in the UK's National Health Service (NHS). At this time the departing Conservative Government, with support across the political spectrum, introduced discretionary powers for local primary care service contracts through its 1997 NHS Act. Following a 1-year period of consultation the new legislation invited members of the NHS 'family', including general practitioners, individual professional bodies, NHS provider trusts and health authorities, to apply for local pilot status. Three new contractual options were offered (NHS Executive, 1998):

- the employment of salaried general practitioners (instead of independent contracting);
- the provision of standard GMS but from an alternative setting to a general practice;
- a framework for the provision of additional services beyond and inclusive of GMS by either a general practice or an alternative supplier.

The overall policy objective was 'to be sufficiently flexible to meet local needs effectively' (NHS Executive, 1996). For the first time in the UK, alternative providers of primary care, including nurse practitioners, salaried primary care teams (with general practitioners) and NHS trusts were recognized and legitimized as appropriate sources of what the succeeding new Labour Government termed 'personal medical services' (PMS).

Between April and October 1998, the first wave of 87 PMS pilot sites became operational. The scheme proved popular. By 2000/2001

Address for correspondence: Professor Geoffrey Meads, Centre for Primary Health Care Studies, University of Warwick, CV4 7AL, UK.

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annual recruitment led to 25% of general medical practitioners in England expressing a formal interest in leaving the standard general medical services (GMS) contract in favour of locally negotiated terms of employment (Secretary of State for Health, 2000). The PMS scheme became, within a relatively short period, firmly established nationwide. Alongside the revised GMS contract issued for consultation in April 2002 it was regarded by government as an important feature in the major resource management roles transferred from district and regional health authorities to the new NHS primary care trusts. These have responsibility for three-quarters of the annual £60 billion public health care expenditure (Pownall, 2002).

Over the past 3 years many of the PMS pilot sites have witnessed the extension of primary care into community-based services located away from those surgeries which were the sole contractual focus when only GMS terms applied. This extension has required, at local practice level, enhanced organizational capacity to both develop and then to sustain the new services. Throughout those sites, studied as part of the national evaluation of PMS pilots, which have targeted health inequalities and the health care needs of the most marginalized patient groups, this increased capacity can be attributed to two principal sources. First, internally PMS pilots have utilized more efficiently the range of multiprofessional personnel available within their new provider contracts (Riley *et al*., 2002). Secondly, externally, more effective use has been made of other agencies and, in particular, non-NHS organizations (Leese *et al*., 1999). This combination of collaboration and partnership has led to new ways of working. It has also placed the PMS pilots in the mainstream of global service developments for population-based primary health care, as opposed to individualistic primary medical care, underpinned by the World Health Organization's fundamental principles (or pillars) of equity, participation and intersectoral alliances (Macdonald, 1992).

## Case study approach

In the concluding phase of the evaluation of the first wave of PMS pilots over the 1998–2001 period both the Department of Health and a number of district health authorities requested the preparation of a series of local case studies to illustrate and examine the kinds of organizational developments described above. The purpose of these case studies has been descriptive and exemplary. Methodologically the case study approach was appropriate 'as a strategy for empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence' (Robson, 1993:5). Together the studies constitute a position statement which demonstrates the nature of some of the changes taking place. Although too few in number to justify either generalizable conclusions or theoretical insights, as indicators of local development they merit consideration in the future formulation of policies for primary care.

In social policy research terms they describe the emerging organizational phenomena with a level of definition sufficient for further analysis to occur through the deliberate control of the specific variables identified (Mayer and Greenwood, 1980).

The case study sites were selected as a purposive sample of those 41 first-wave PMS pilots targeting inequalities in access to health care for such vulnerable populations as homeless and severely mentally ill people. Three of the case studies were based on sites that had been visited previously as part of the national evaluation sponsored by the Department of Health (Carter *et al*., 1999) with the additional site drawn from a separate complementary study supported by the West Midlands NHS Research Network. This selection reflected the variation of PMS pilot sites in terms of range of multiple focus target groups; alternative provider units, location and size; and different forms of local contract and contracting agent including standard and extended PMS terms of agreement. The four sites are summarized in terms of key variables in Table 1 below.

Collectively the case study sites have a broad geographical spread, with each PMS pilot focusing on the particular needs of one or more different patient groups. At each site semistructured interviews were undertaken with three sets of professional groups to provide a broad perspective of how professional relationships had developed. The 'lead' general practitioners were included at each location. The other interviewees were the

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**Table 1** PMS case study sites

| | Location | Type | List size | Health need/ inequality | Interviewees |
|---|---|---|---|---|---|
| Case study 1 | Southern counties | Standard practice PMS | 17000 | Mental health and learning disabilities | GP, nurse practitioner, community psychiatric nurse |
| Case study 2 | Northern city | PMS plus practice | 1200 | Alcohol and drugs misuse, homelessness, mental health | GP, sessional worker, practice manager |
| Case study 3 | South coast | Trust-based PMS | 700 | Refugees, alcohol and drugs misuse, mental health | GP, nurse practitioner, practice manager |
| Case study 4 | Outer London | Interpractice PMS | 12000 | Ethnic minorities, elderly care | GP, nurse practitioner, practice manager |

named local site 'coordinator' and a representative from the individual primary care team (e.g. a community nurse). The interviews were tape recorded and transcribed, with the individual's permission. The data augmented the documentation and information gained from earlier telephone surveys and site visits, as reported in a thematic analysis elsewhere (Riley *et al*., 2002).

Professional boundaries, practice culture, political cohesion and collaboration (for health promotion rather than medical care) were the four themes defined in this last study. In the present study these were aggregated and interviewees were initially asked to examine the critical developments in organizational relationships, identifying in particular the most important new alliances. In the second part of the interviews, assisted by four checklists of research-based criteria for both interprofessional collaboration and the formation of interagency partnerships (Table 2), the local subjects identified those statements in the checklists which were most relevant (if at all) at their PMS pilot locations. These checklists were based on theoretical models currently in widespread use amongst emerging 'modernized' health care organizations, including

**Table 2** Models of interagency partnership and interprofessional collaboration

| | Model 'A' Interactive learning | Model 'B' Supraprofessional frameworks |
|---|---|---|
| Stage 1 | Achieve common understanding – concepts, language, knowledge | Professions find (more) commonality with other professions |
| Stage 2 | Overcome prejudice – bias and stereotypes | Values of trust and service shape relationships |
| Stage 3 | Modify behaviour – change cultural norms | Team structures 'socialise' across professions |
| Stage 4 | Reinforce common ground – combine complimentary skills | Joint goals harness professional and bureaucratic resources together |
| Stage 5 | Identify joint opportunities – agree actions (Barr, 1999) | User outcomes demonstrably drive interprofessional contributions (Guy, 1986) |
| | **Model 'C' Collaborative advantage** | **Model 'D' Relationships management** |
| Stage 1 | Identifying omissions – joint service gaps | Directness of communications and integrity |
| Stage 2 | Recognizing duplication – waste and inefficiencies | Parity of respect, risks and benefits |
| Stage 3 | Divergence – separating from central purpose to secondary goals | Continuity – regularity of interaction over time |
| Stage 4 | Disputes – conflict avoidance | Breadth – mutual understanding of roles, context and agendas |
| Stage 5 | Commonality of function and purpose (Huxham and MacDonald, 1992) | Commonality – of values and purpose (Schluter and Lee, 1992) |

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NHS primary care trusts (Ashcroft, 2001; Barr, 2002). Those summarized in Table 2 are of collaborative advantage and partnership management (Huxham and MacDonald, 1992; Schluter and Lee, 1992), collaborative learning across professions (Barr, 1999), and a classic framework for 'interprofessionalism' (Guy, 1986). In addition to their contemporary utility and relevance as development aids to new primary care organization these models were chosen because of their particular emphasis on the preconditions for effective relationships and their linear form. As such they offered a readily accessible means of self-assessment for the PMS pilot site participants directly in accord with the sequential approaches being adopted in the development of their individual PMS pilots. The use of these trigger mechanisms proved an especially productive source of data and development and the following narratives reflect those checklist criteria chosen by interviewees as a result.

## Case study 1

This south of England pilot operates to a standard PMS contract covering the 17 000 registered patients of two group practices located in a relatively affluent area. Their original objectives included the improved management of the health care needs of local people with severe and long-term mental illness and learning disabilities through improved multidisciplinary teamwork.

As this site, in September 2001, there was ambivalence about the future of the PMS contract and organization. At this time, a one year extension of the PMS pilot terms to March 2003 was all that was anticipated. The PMS contract was viewed as essentially a short term tactical exercise, which had been particularly beneficial in progressing further the gains that had begun to be made in terms of integrated local nursing services under the previous GP fund-holding scheme. PMS was not regarded, however, as a viable long-term strategy for the organizational development of primary care. There were two agreed reasons for this. First, there was the perceived lack of management capacity required at practice level to sustain PMS development. At this site a severe health authority deficit had led to the withdrawal of the dedicated PMS project manager in 1999/2000. The following statement by one of the practice's nurse practitioners highlighted the concern.

> I think the crunch for me was when we lost the person who was in the overall manager role ... then the focus of attention of the pilot was lost because that money was stripped away.

Subsequently the PMS professional 'leads' said they felt fatigued and that their personal enthusiasm for the scheme had been exploited. Moreover, the advent of local NHS primary care groups (PCG) meant there was a general expectation that future service innovations would be both generated and maintained managerially at the suprapractice level of the NHS primary care trust. Accordingly, the current PMS 'lead' GP was arranging for the PMS pilot's programmes for the audit and registration of severely and long-term mentally ill people to be made available to the relevant PCG working group and through the PCG chief officer to the government's national Primary Care Collaborative programme. The agenda for primary care development was regarded at this site as having moved, during the lifetime of PMS, from being locally to being centrally determined with practices reverting to simple frontline healthcare access points and clinical provider functions. In the words of a local health authority's strategy:

> The NHS is required to adopt a structured, coherent approach, placing duties and expectations on local health care organizations as well as individuals ... primary care trusts are these fledgling organizations moving their constituent members through a process of change which is both fast paced and developmental.

The defensive reaction was linked closely to the second reason for the sense of ambivalence about PMS as an organizational development. This was both financial and economic. The concern was that continuing budgetary constraints could both restrict such further organizational developments as the nurse practitioner's role under the term of PMS, and also potentially threaten the overall personal incomes of GP principals (and their

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normal levels of growth). While it was acknowledged that PMS had led to significant process gains in terms of better communication, shared information and reciprocal awareness between professionals across the two general practices, there was no question of the general practitioners subsidizing from their partnership profitability such supplementary services as cholesterol screening and care management. These had been developed by the practice and, in particular, by community mental health nurses under the terms of PMS. If necessary, these would not continue to be supported:

> The government sees mental health as a priority and are making sure that everybody is aware. But the project will not survive. The money will be spent on new hospital services. That's the real trust priority and there's no provision for local PMS evaluation. ('Lead' GP)

This pilot was becoming increasingly concerned about the politics of PMS. Initially the impact of the new contract had been felt by the 'lead' GP to be 'liberating', not least in terms of 'releasing' both GPs and nurses from the restrictive influences of their professional associations and committees. However, her concern now was that PMS was becoming the 'Trojan horse for a new managerialism', principally in the guise of the primary care trust as NHS performance manager, threatening what she said her colleagues viewed as the traditional independence of the individual general practice, the solidarity of peer-based professions and ultimately their personal relationships with 'their' patients.

> It's (PMS) not for the faint hearted!
> ('Lead' GP)

Notwithstanding these future concerns, in 2002 organizationally the south of England pilot could still point to several significant advances as a result of its PMS contract. The integrated cross-practice nursing team had developed a series of flexible ways of working as a result of agreeing 'joint goals' and 'common purpose' within the confines of the health centre. Practice nurses were now actively involved in the preparatory monitoring of patients with mental health risks; a combined wound management clinic had been set up and district nurses were now engaged in post-clinic home visits to patients with diabetes. By bringing a community nurse manager into the team they had also been able to organize a practice dedicated health visitor for older people. This had been a significant organizational and service development. 'Directness' of communication was the key attribute of relationships within the PMS site and accepted as a basis for further partnership working (Ashcroft, 2001):

> We have broken down the professional barriers so that we keep our expert skills, but use them in the most appropriate way.
> (Nurse practitioner)

Externally the PMS contract has led to the pilot staff becoming members of a community mental health services network alongside local volunteers, the new consultant psychiatrist, and the community psychiatric nurses who now formally service and support those on the PMS register for severe mental illness (SMI) at regular intervals. The community psychiatric nurse interviewed also referred to still regular but fewer incidences of inappropriate referral, and a lack of understanding of mental health issues by GPs in one of the practices in particular. Overall, however, the PMS experience has heightened a general awareness at the PMS site of the need to similarly address the requirements for more effective working partnerships with external agencies in the areas of child protection and elderly persons at risk. While PMS for several GPs was described as a 'bureaucratic threat' best confined to areas of high socioeconomic deprivation, it has nevertheless been a means of moving towards primary care teamwork in its fullest sense at this home counties location. As the following quotes indicate, the pilot was seen as a partial success:

> Relationships between doctors and nurses are better, but they are still quite detached.
> (Community psychiatric nurse)

> Now at least we actually know who our nursing staff are. ('Lead' GP)

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## Case study 2

This northern city pilot represents the conversion of a general practice with standard general medical services into a 'PMS plus' contract. The GMS practice had been a longstanding health authority project targeting homeless people and travellers with their associated problems, including mental illness and alcohol and drug misuse. In contrast with case study 1 at this site the PMS contract in September 2001 was regarded as a long-term strategic initiative, legitimizing not just the particular service but the NHS as a genuine 'community organization' (Meads and Ashcroft, 2000). As such, the PMS site was authorized and accepted by a series of local partner organizations in a series of resource sharing initiatives. The overarching values of 'trust' and 'service' in the selected theoretical model of interprofessionalism (Guy 1986) were seen to 'form' cross-boundary relationships. These included such local and national nonstatutory organizations as Shelter, the Shaftesbury Society, the Simon Community and The Big Issue. The NHS community and mental health trust provided organizational support for the management of the service, with a new practice manager post being created to relieve the administrative burden on the 'lead' GP.

This incorporation of the PMS site into the mainstream of community services development has also led to its formal recognition as a teaching practice offering part of a community-based module to GP registrars, and to the adoption of a series of shared care protocols with the city-wide community mental health service. Local authority planning and financial support had also been forthcoming and the need to work as part of one of primary care's new 'virtual organizations' (Meads and Meads, 2001: 32), comprising both public and voluntary sector units had led to significant changes in the internal organization of the PMS. It was no longer recognizable as either a conventional general practice or as an NHS institution. Responding to patients in a more holistic way as part of a network of community resources working towards meeting the full range of human needs, with all the liaison and service co-ordination demands this brings, had led to the introduction of posts and functions no longer titled or based on single professional disciplines: e.g. 'support worker', 'sessional healthcare' (by visiting dentists, welfare benefits advisers, alcohol counselors, etc.) and 'co-ordinators'. The key changes brought about by PMS, as highlighted by one of the support workers, was that a multitude of services were now being provided under one roof for homeless people in the area. He commented:

> Under the old system only the health authority gave you money: now it is a completely new set of people involved.

While still multi-, rather than fully, interdisciplinary, members of the PMS core team used the five stage scale of interactive learning to both recognize that their skills are complementary and to reinforce the common ground (Barr, 1999). If in case study 1, as in many other new primary care agencies, issues of professional parity still serve as the major obstacle to increased internal collaboration (Ashcroft, 2001), for case study 2 the closer partnerships with traditionally low status community agencies has meant that parity—or the perceived lack of it—has sharpened differences between the PMS and the powerful local secondary care sector. Here the loss of past NHS status seems to have proved a disadvantage. Without direct health authority management and diminishing direct profession-to-profession clinical links the personal medical services site has itself become 'semi-detached' from NHS policy and performance. It has been unable to develop, for example, more effective acute care referral and discharge arrangements. The salaried GP commented ruefully:

> We do our primary care bit, and the longer we stay open the more secondary care bits we do.

In this context the advent of NHS primary care trusts (PCT) was anticipated with a sense of both risk and opportunity. The fear of the PMS sessional worker was that the new corporate organization could 'bureaucratize' the PMS, limit its local priority and finance and, as elsewhere, operate with its secondary care counterparts to the rationing agendas of a primary managed care rather than a primary health care regime (Robinson, 1996). The more promising and likely scenario, however, saw the PCT as a strong future ally introducing its own community-based

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strategies and accreditation arrangements, supported by joint investment plans that, for example, enable the PMS site to move to common computerized databases with local churches and housing associations. The PMS had been encouraged by the way in which the local PCG had included one of its 'lead' GPs into its executive membership and encouraged pairing arrangements with other practices. The pilot site coordinator's review was positive:

> They (the government) have put more resource into the community. There has been a lot more communication going on between the voluntary agencies, and, you know, other organizations. Ours is a community-based multidisciplinary model, and we get the support of the people in the community.

This northern city PMS acquired NHS national 'beacon' status. It sees its position as having been 'regularized' by PMS. What its staff term as its 'flexible/psychosocial' model has become progressively more accessible to its target patient groups with a 'no-turnaway' policy now successfully implemented and supported by a range of contact points from hostels and day centres to crypts and street corners. PMS staff serve as management committee members for the host agencies of the hostel and day centres. The next steps could be for local NHS organizations to open their doors to similar representative arrangements in return through the brokerage of the PCT. The continuing joint identification of service gaps and commitment to a shared 'mission' served as the chief drivers of organizational development for this PMS, but against a local background of still uncertain NHS support. The 'lead' GP concluded:

> One of the things that is unfair is the way that others (in the NHS) haven't got as many ethnic minorities as we have. They have chosen that for a reason and I guess it's because we are more accessible, more welcoming: more in the spirit that here is this population that has their needs and we are the service provider. But we have never got to grips with the issue of inequalities: we have tried to provide a service but we haven't been resourced to do it.

## Case study 3

This coastal region pilot was an NHS trust-based PMS scheme targeting the healthcare needs of homeless people, including a substantial number of refugees. It had on average 700 registered patients. Its 'core' team was a general medical practitioner, nurse practitioner and practice manager, all of whom were salaried employees of the NHS trust.

This status had led to two distinctive organizational developments at this PMS pilot, which, in most other ways, parallels case study 2 as a community organization, with a network of enhanced local relationships in which the local mental health, alcohol and drugs misuse and voluntary services again feature prominently. These developments were the creation of new specialist primary care professional roles and the operation of a peer-based clinical team subject to general management. The two developments were interdependent:

> There is a new breed of animal, which is starting to come in: (for example) the GP consultant, the specialized nurse practitioner.
>
> ('Lead' GP)

The role of specialist practitioner is best exemplified by the role of the former district nurse at the project. She had been released by PMS to undertake not only a wider range of care functions, ranging from prescribing to health promotion, but also to actually become what she terms as 'the principal relationship' for some patients, particularly in her outreach role. For the specialist general medical practitioner, having this 'more equal relationship' has served as a release from the 'very hierarchical sort of arrangement with the GP sitting somewhere very nice at the top of the triangle', enabling him to become part of 'a proper team' with 'open communication' and 'open mindedness'. For the general medical practitioner building this team and its associated clinical and community networks was at the heart of his specialist role for homeless people. He saw it simply as the basis for better care. The community psychiatric nurse from the homeless mental health team described the role of this general medical practitioner as 'invaluable' to their team.

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The essence of the impact of the PMS contract within the overall strategic management of an NHS trust is well captured by the following words from the nurse practitioner. Referring to the PMS team she said:

> I really do believe that this model has been to the benefit of clients, definitely. And it is one of the jobs I have been in where the client has been at the forefront of the way we've driven the service here. Just going back to GMS, in GMS obviously the care you give is driven by the reward you get in your payments and out of the service. Well, we don't have that here. There is no drive to ensure that everybody has a smear. It's good practice, and we would encourage others to go down that route.

As this quote illustrates the whole relationship with service users has been adjusted by the terms of PMS. The word 'client' has replaced patient. Primary care has become incentivized through a team's service ethos rather than by the need for individual income generation. Again, in the words of the nurse practitioner:

> It's interesting isn't it because that puts you very much on a par with the person you're working with.

At this PMS the new sense of equalities between professionals and with the public meant that the participants had moved beyond the stages of establishing common ground and sharing complementary skills and expertise to actually pursuing integrated-professional joint developments. The general medical practitioner is content to work with the nurse's expanded role although with responsibility and accountability still in the hands of the doctor, and his experience taking precedence where there were recognized '*limits of her expertise*'. The sense of common purpose was not being undermined here by issues of parity and the other preconditions set out in the selected partnership model (Schluter and Lee 1992) for effective working relationships–breadth, directness and continuity–were seen to be firmly in place. As a result, the drop-in clinic and outreach services of this PMS pilot have already become as much part of the NHS landscape, for other agencies, as the local standard general practices.

## Case study 4

This outer London standard PMS pilot was unusual in that it incorporates two separate general practices with three branch surgeries and a sharply differentiated local population. Accordingly the separate service outlets responded to the very different needs respectively of a young Asian community, more established Turkish and Greek neighbourhoods and a large traditional housing estate with a high proportion of indigenous older residents. The health needs profile ranged from above average incidences of diabetes and mental illness in the former to shortfalls in intermediate care facilities for the latter. The pilot was based in a location to which it had long been difficult to recruit and in 1998 the 11000 patients were being served by only two full-time registered general practice principals.

Three years later, by adopting a corporate management approach to the split sites and diverse patient groupings, the PMS pilot had achieved significant increases in overall service levels and performance. These included, for example, a weekly rota of 14 health promotion clinics, all approved in the government's top branding; maximum screening and vaccination target levels, and unified teams for community nursing, midwifery and social work. This enhanced interprofessional work was mirrored by improvements in external communications with the PMS pilot's 'care of the elderly' programme co-managed by the practice in partnership with the local community health and district councils and Age Concern. Over the 3 years since its inception the pilot had gained 9% more patients, all of whom were guaranteed GP access within 48 hours.

> Local and small is beautiful. It is better than being a number in an organization.
> (Practice manager)

Skills mix and substitution issues have been at the heart of this pilot's approach to interprofessional collaboration. A portfolio of employment options have been developed, each with different professional development opportunities, for both general medical and nurse practitioners. One of the latter's roles has become the equivalent of a principal GP, while there have been four salaried general medical practitioners so far working to

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short-term and part-time contracts. Over £30 000 has been estimated to have been saved by moving from separate surgery-based practice managers to overall PMS general management.

In terms of the collaborative advantage set out in Table 2 (Huxham and Macdonald, 1992) the need to avoid duplication and divergence was identified by interviewees as the compelling force for positive innovation in the direction of a modern managed care service model. PMS has paved the way for more efficient local resource utilization. The two GP partners have substantially increased their value – both personally and professionally. They have turned the general management approach, adopted by the NHS trust in case study 3 to develop a peer-based clinical team, to their own advantage. In case study 4 there was very definitely no change to the traditional professional pecking orders of UK primary care. If anything, the dominion of general medical practice was strengthened.

## Conclusions

The four case studies illustrate the capacity of the current PMS programme to stimulate and sustain very different types of primary care organizational development. Their methodology points to the scope for research to support such developments through the apposite selection and use of relevant theoretical models. At the local pilot sites considered, the range of solid innovation is impressive, from integrated community nursing teams and support networks to more flexible health care roles and conditions of employment. Such developments are recognized as appropriate responses to both particular local needs and to different professional agendas, with the latter still the more influential in shaping the patterns of relationships with both internal participants and external partnerships.

The case studies, however, also highlight the restrictive, as well as the progressive aspects of PMS practices, with the importance of sound management structures that ensure parity between professionals and their communities emerging as the most important single theme for future policy formulation. Without such management PMS may be at risk of being as marginalized by the independent general practice still prevalent in much of UK primary care as the patient groups the PMS pilot sites in our case studies were striving to serve.

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